PRIMARY CARE CASE STUDY 0884

Primary Care Reform in Issyk-kul Oblast

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1.0 INTRODUCTION

The most comprehensive, and probably the most successful, strengthening of primary health care services throughout the new independent states (NIS) has occurred in Issyk-Kul Oblast, Kyrgyzstan. The centerpiece of the Issyk-Kul reform is the "family group practice," a newly established health care institution consisting of 2-3 different physician-specialists plus nursing support, which is to be responsible for providing the full range of primary health care services to its patients. The family group practice, or FGP, is expected to become a prototypical provider of primary health care: that is, it will deliver both preventive, as well as a wide range of curative services, exclusively for ambulatory patients; and it will spend considerable time and effort on health education and the promotion of health lifestyles and practices. It is hoped that eventually the FGP will be able to meet on its own as much as 80-90 percent of the health care needs of its patients, without the involvement of other specialists or facilities. By reducing substantially the utilization of other, generally more expensive facilities and specialists—a result both of improved health status and of the increased range and volume of services provided at the primary care level—FGPs should help to limit, or even reduce, the current budgetary cost of health care and to increase the impact of the funds that are available.

Neither the objective and rationale of improved primary care, nor many of the specific aspects of the FGP reforms, are unique to Issyk-Kul Oblast. At the same time, these reforms are still in their early stages; and so claims of the reforms' impact on clinical performance or economic effectiveness would be premature. Nevertheless, there are three things that set the Issyk-Kul reforms apart from similar efforts to strengthen primary care that have been undertaken elsewhere in the NIS. First is the *scale* of reform: FGPs provide coverage to the entire oblast; already more than five-sixths of the oblast's population has enrolled voluntarily with one or another FGP. Second is the *political commitment and perseverance* of the oblast administration. Although support from international donors has played a critical facilitating role, the reforms were conceived and begun well before the donors' arrival in Issyk-Kul and could not have progressed nearly as far as they have without the continuous, skillful leadership that local officials have shown. Third is the *scope* of reforms which are a complex, integrated *package* of organizational, educational, financial, management, marketing, and information system changes that is far more potent and significant than the sum of its parts. There is in Issyk-Kul much fuller recognition than elsewhere in the NIS that the strengthening of primary health care is genuinely "radical" health care reform, and that it requires fundamental, more or less simultaneous, and mutually reinforcing changes not only in the organization, delivery, financing and management of care, but also in physicians' knowledge and skills, in patients' knowledge and behavior, and in the mechanisms used to ensure the best possible quality of care and to measure and monitor performance.

The remainder of this report is divided into two parts. In the next section, the main features of the Issyk-Kul reforms are described in some detail. In Section 3.0, the main causes of, and limits to, the Issyk-Kul reforms are presented and discussed.

2.0 MAIN FEATURES OF THE ISSYK-KUL REFORM

2.1 Organization and Delivery of Care

At this writing (April 1997), a total of 81 FGPs have been established, in which a combined total of 187 physicians and 247 nurses are employed. FGPs in urban areas have enrolled approximately 5,400 persons, on average; for FGPs in rural areas, enrollments average about 6,700.[1]

An FGP typically consists of 2-3 physicians—an internist, a pediatrician, and a part-time obstetrician-gynecologist—plus nursing and other support.[2] In addition, each FGP is assigned a part-time "practice manager." Practice managers (PMs), most of whom serve an average 2-3 FGPs, assist the physicians with financial reporting and other aspects of practice administration—functions that will become increasingly difficult and important as financing flows increase. PMs also have taken the lead in developing and implementing a health management information system, consisting of both clinical and economic indicators, which is essential if the planned financing reforms are to be fully realized.

The first four FGPs in Issyk-Kul oblast were established in Karakol City by the order of the Oblast Health Department in October 1994. The following May, local authorities agreed to establish FGPs, and to institute voluntary enrollment, throughout the oblast. While the first FGPs were formed by administrative fiat, the next 12 could be said to have been a joint result of: continued pressure from the head of the Oblast Health Department, on the one hand; and, on the other, growing interest on the part of physicians who were intrigued by the concept of family care, but who also were motivated by the opportunity to obtain basic clinical equipment thanks to a grant from USAID's Zdrav*Reform* Program. The final 65 FGPs were established mainly at the physicians' initiative—perhaps both a "bandwagon effect," but also linked to a spreading realization that the physicians needed to re-orient their thinking to adapt to reforms.

Presently, 32 FGPs are fully operational, with renovated premises and a complete inventory of equipment and tools. The remaining 49 FGPs are in various stages of becoming operational: either necessary renovations have not been completed; the necessary equipment has not yet been supplied; the physicians still are undergoing initial training (see below); or the practice is able to provide only some of the expected services. Originally, it was thought that more than 200 FGPs would be needed to provide coverage for the entire oblast; however, the 81 established so far now are thought to be more or less adequate.[3]

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[1] Rural FGPs are assigned, on average, three feldsher units which both refer patients to the FGP and act as "extenders" of the FGP, thus enabling the FGP to handle the higher patient load.

[2] There are fewer trained obstetrician-gynecologists available, and they, as a result, generally work for two or more FGPs.

[3] In principle, new entry is possible, and physicians who are not presently affiliated with an FGP can form new ones. However, entry is controlled by the Oblast Health Department which is responsible for examining applicants' qualifications and experience and for comparing and assessing applicants on a competitive basis. Not surprisingly, new entry in practice has so far been limited to the replacement or

All FGP physicians remain employees of the Ministry of Health (MOH) of Kyrgyzstan and, therefore, are subject to the salary schedules and other rules of the MOH, including the regulations of the sanitary-epidemiology service (SES) and applicable *prikazy* (see below). In addition, all FGP physicians and nurses remain assigned to their former polyclinics; and some continue to be required to serve "duty calls," to attend staff meetings, and to perform other obligations normally expected of the polyclinics' regular staff. On the other hand, many FGPs are physically removed from the polyclinic, and those that remain in the same building generally have separate entrances and their own, clearly demarcated sections within the facility. The FGPs that remain physically situated within the polyclinic typically depend on the latter for a number of services, i.e. janitorial, linen, cleaning supplies, etc., and this may lessen the physicians' independence from the facilities' chief physicians. Nevertheless, on balance, it appears that FGPs have secured, and are exercising, a considerable amount of autonomy.

2.2 Access to Care by Patients

A key feature of the Issyk-Kul reforms is the emphasis given to consumer involvement and choice. A necessary condition of strengthened primary care is that individuals and families become more actively involved in, and take more responsibility for, their care; one way to encourage this is to give consumers the right to choose from whom to receive care. As a rule, FGPs are required to seek enrollees; subscribing families and individuals are free to choose among licensed FGPs; and in the future, subscribers will be given the opportunity periodically to "dis-enroll" and/or move to another provider.

These goals have been achieved, in practice, thanks mainly to an inventive, aggressive, multi-media marketing campaign designed (1) to introduce and explain the FGP concept to citizens and (2) to encourage and enable families and individuals to sign up formally with one of several, competing FGPs. The campaign, which included development of an FGP logo, informational brochures, public speeches, and other Western-style marketing activities, was pilot tested in the winter of 1996; it was then "rolled out" to four districts and Karakol City in May 1996 for a period lasting several weeks; and during the summer it was extended to the country's remaining districts. As of December, 1, 1996, a total of 354,015 people had enrolled with an FGP, 86.8 percent of the oblast population (407,848).[4]

Originally, it was planned to give subscribers an opportunity to switch providers during an "open season" lasting one week twice each year, beginning in December 1996, six months after the enrollment campaign of the previous spring. However, on account of the high costs of the campaigns and the shortage of marketing staff, this plan was never implemented. Currently, an effort is underway to develop an inexpensive means by

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reinforcement of an FGP which has lost one or more of physicians as a result of marriage, administrative transfer, or some other event.

[4] The actual percentage may be higher, since there are various groups of individuals residing temporarily in the oblast who receive health care services from separate providers (e.g. the KGB, the army, the border guards, the, police, etc.) and who are sometimes included in the oblast's population totals.

which patients can switch FGPs, which would allow an "open season" to be held either once or twice a year.[5]

Patients enrolled with an FGP are not currently required to utilize its services. Enrollees still are permitted to seek care from state providers, and thus to bypass the FGP; anecdotal evidence indicates this happens frequently (as reported in Idar Rommen's case study). Once the planned financing reform has been instituted, however, it is expected that bills submitted by non-FGP providers to the Mandatory Health Insurance Fund will have to be co-signed by a patient's FGP, or they will not be paid.[6]

2.3 Financing of Care

Currently, FGPs are financed directly by the Oblast Health Department. Physicians and other staff continue to be paid at the rates that prevailed before FGPs were formed., i.e. according to established MOH pay schedules.[7] A similar situation exists with respect to other costs. For example, FGPs that are physically separate from "their" polyclinics have been allowed to negotiate no-cost leases which, in most cases, include the cost of utilities. In other cases, utility and other costs either are paid by the organization in whose building the FGP is located or are paid directly by the Oblast Health Department.

Although direct financing by the Oblast Health Department is meant to be only an interim arrangement, pending the introduction of full FGP fundholding (discussed below), it is potentially unstable for several reasons. First, no basic package of services has been defined, which FGPs are obliged to provide; this creates an incentive for FGPs to shift costs to other providers, as well as a danger that the FGPs' resources will be insufficient to meet the demands placed on them by expectant subscribers. Second, it is unclear whether FGPs will be able, or likely, to seek from their patients limited cost-sharing, either for normally provided services or for "supplemental" services, e.g. special home care. Previously, some oblast facilities were allowed by the Oblast Health Administration, in certain circumstances, to charge a small co-payment (less than $0.20) for initial visits. However, the Kyrgyzstan Constitution explicitly prohibits public health care facilities from charging fees; the public's attitude toward user fees is reported to be quite negative; and facilities generally lack the internal controls and procedures needed in order to assure proper accounting and use of collected fees. For all of these reasons, FGPs do not require a co-payment, nor are they actively seeking such authority. That said, the Center for Excellence, which functions simultaneously as a demonstration FGP, is quietly experimenting with a flat fee for certain kinds of home visits.

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[5] In December 1996, a "mini" re-enrollment campaign was held in Karakol, following the merger of two FGPs that, combined, are to supply the training staff for the Center for Excellence training facility (discussed in Idar Rommen's case study). Because the merger has altered fundamentally the services provided to subscribers, the latter were given the opportunity to re-enroll, or to switch to another provider, so as to ensure than no one would feel that he or she had been deceived or misled.

[6] Emergency services will be exempted from this requirement; however, these services are not expected to be financed directly by the Mandatory Health Insurance Fund.

[7] This means, among other things, that FGP staff, like others in the state system, often are paid as much as 3-4 months late and, sometimes, with commodities, not cash.

As noted, it is planned that FGPs will become "full fundholders." This means that FGPs are to be given the responsibility and necessary funds to finance the complete cost of a patient's care from beginning to end, including the cost of diagnostic work, specialist consultations, and any inpatient care that might be required. Funds supplied to the FGPs are to be based on a pre-set, risk-adjusted capitated rate per enrollee, which takes into account the age-sex mix and other relevant characteristics of the enrollee panel. FGPs are to contract with, and to pay, other providers for any care that they cannot supply themselves.

The development of "fundholding" has barely begun and obviously will require a considerable amount of time. A major reason is uncertainty: both with respect to the likely availability of funds, which no one can predict with even rough confidence more than a year into the future; and with respect to the likely cost associated with a given panel of enrollees and, therefore, whether one or another capitated rate will be adequate for even the most efficient of FGPs. In addition, adequate management systems need to be established that will enable FGP physicians to monitor their costs and to pay their bills. Currently, a limited pilot experiment with fundholding is being conducted in four FGPs in Karakol; the experiment is scheduled to be completed and evaluated in June 1997, after which it may be extended.

In the meantime, it has been proposed to institute fundholding in stages, first by giving FGPs the responsibility and funding necessary in order to arrange a limited amount of additional outpatient care (certain diagnostic tests and specialist consultations) according to pre-set fee schedule. However, although a fee schedule was completed in June 1996, it still has not been implemented. Reportedly, the calculated fees were based on "outdated" or grossly inflated costs and are now viewed as excessive and unsustainable. Yet, would-be providers of these services (facilities and specialists), which are facing the threat of declining patient flows and revenues on account of the FGPs, are said to be resisting any alteration in the fee schedule, while no mechanism has been developed for reviewing rates in the light of changed circumstances and/or accumulated experience.

2.4 Management of Care

A novel and critically important feature of the Issyk-Kul reforms has been the introduction of Practice Managers (PMs), whose role is to help FGPs operate with maximum efficiency and to prepare them to assume the responsibilities and risks associated with fundholding. Training of the first PMs was begun in March 1996; by October 1996, 30 PMs had been hired and were being trained. PMs have received instruction in the principles of health care and health care administration, as well as in a variety of more "generic" management-related subjects, including statistics, financial analysis, inventory management, and use of computers. Initially, physicians were said to be skeptical of the need for PMs, but, according to one observer, nearly all of the FGP physicians have been "astounded" by their PMs' capabilities and achievements.

A total of 24 desktop computers are available for use by PMs in the oblast as a whole, and all FGPs have access to at least one. In Karakol proper and its suburbs, PMs have access

to the "Practice Manager Computer Center" which is equipped with a network and 10 workstations.

In order to enable FGPs to begin to operate as business entities, both financial and clinical information systems are being developed. The first stage, begun in 1994, has consisted primarily of data collection, on the basis of "primary care clinical data worksheets," concerning workload, referrals, ICD-9 diagnosis coding, and so forth. These data, once entered and regularly updated, will allow PMs and others to monitor and measure differences and trends in clinical and management practice over time. The second stage, begun in 1996, is aimed at constructing basic finance and accounting systems; these already are being implemented step-by-step.

2.5 Training of Physicians

At present, physicians employed at FGPs are not required to receive special training, nor do they require special certification in order to work in this capacity. Certification criteria and associated training requirements eventually must be established, but this probably will not happen until an official "specialty" in General Practice and/or Family Medicine has been established and recognized within the Bishkek Medical Academy.

Nevertheless, physicians slated for work in the FGPs are receiving training in family practice at the Center for Excellence, located in Karakol. The program, which is financed by USAID, was organized and continues to be directed by an American family practitioner, Dr. Idar Rommen, from Seattle, Washington. Dr. Rommen has been assisted by a second American family practitioner, Dr. W. Bradlee Gerrish, who is associated with the U.S.-based NGO, "Science, Technology and Learning Institute (STLI)," located in Bishkek. Designed to last nine months, the program operates five days a week and consists of approximately three hours per day of classroom lectures and peer-led cross-specialty training, plus three hours of supervised clinical practice. It is hoped that the majority of those who complete the program in the first wave will go on to train other physicians and physician-trainers. Approximately 50 physicians are expected to complete the program annually.

The Center and its program were visited in the fall of 1996 by the Director of Staff Training and Certification at the MOH and the Head of the Postgraduate Medical and Pharmacist Training Institute, also at the MOH. After inspecting the program and reviewing the FGP training curriculum, the delegation registered their verbal approval and asked permission (1) to dispatch physicians from elsewhere in Kyrgyzstan to the Center for additional training and (2) to use the curriculum as the basis for training programs then being organized in Bishkek. Unfortunately, this visit has not so far led to formal recognition of the program at the national level and, as a result, the program's status and that of its graduates remain informal and uncertain.[8]

[8] Formal recognition must come from both the MOH and the Ministry of Higher Education.

2.6 State Regulation and Quality Assurance

There are no official standards for physicians who work at FGPs—nor for solo Family or General Practitioners—since, formally, these specialties have not yet been recognized in Kyrgyzstan. FGP physicians must undergo the same continuous reexamination of their medical knowledge, as must all practicing physicians, but otherwise face no additional obstacles to practice.

The health sector as a whole continues to be regulated by an enormous body of "orders," or *prikazy*, which (1) prescribe nearly every activity or question, from clinical treatment to financial reporting conventions to janitorial practices and the like; (2) have accumulated over time and are considered to be operational unless and until they are officially rescinded; and (3) still have not been organized into an integrated system or published in a single, accessible volume. No single institution, not even the oblast health department, appears to have a complete set of operational *prikazy*; and it often is the case that *prikazy* are known to some facilities but not to others. Since new *prikazy* sometimes rescind old ones, the lack of systematization and disparities in available information lead to a constant, sometimes irresolvable series of disagreements among facilities and between facilities and different organs and levels of government. In these circumstances, FGPs and family practice-centered primary health care are inevitably vulnerable, and it often is difficult for FGP physicians to be certain they are in full compliance with existing rules and regulations.

A particularly important question, in this connection, is Quality Assurance. FGP physicians remain answerable to the existing institution of "external experts," i.e., leading specialists in the oblast who are responsible for (i) verifying that physicians are in compliance with all *prikazy* having to do with treatment protocols and (ii) levying fines or other sanctions on those physicians determined to be out of compliance. Many current *prikazy*, read strictly, may prohibit physicians from delivering some of the "general" services that FGPs are expected to provide.

Therefore, in order (i) to prepare the ground for a shift to new, less restrictive and less punitive methods of Quality Assurance, (ii) to encourage FGP physicians to continue to broaden their skills, and (iii) to help enlarge the scope of FGPs services (by identifying *prikazy* that unnecessarily restrict the ability of family practice physicians to treat certain patients), a system of "internal experts" is being developed, i.e., leading physicians in the oblast who support the reorientation of care and who are able to help FGP physicians to identify deficiencies in their knowledge and skills, and to remedy them, before these deficiencies can be uncovered by the "external experts."[9]

2.7 Professional Representation and Advocacy

Two professional associations, one for urban FGPs, the other for rural FGPs, have been established in order to monitor and support the new institutions, to provide oversight of the practice managers, and to lend assistance with grant applications from the FGPs to

[9] Efforts also are being made to open up direct communications and, possibly, cooperation between "external" and "internal" experts.

receive funds from international donors for renovation assistance, pharmaceuticals, equipment, and supplies. The associations are registered with the Ministry of Justice as non-profit, nongovernmental organizations, which allows them to avoid having to pay duties on imported clinical equipment (a major reason for their creation in the first place). Each association has its own seals, by-laws, and bank accounts, which allows it to receive and maintain funds and, more important, to defend from encroachment from the MOH about $70,000 worth of computers and $75,000 worth of clinical equipment, purchased with funds provided by USAID, and roughly $1,700,000 in donated pharmaceuticals.

In establishing the associations, it was hoped eventually to create an institutional structure free of government control in order that, in the future, when FGPs are perhaps able to move in the direction of private practice, there would be an organization available to which FGPs could turn for training, coordination, administrative support, representation, and advocacy. Total membership in the two organizations consists of the 187 practicing FGP physicians, plus one of the Practice Managers who, although not a physician, heads the rural Family Group Practice Association.

Apart from their heads, who are non-paid, the associations have no regular staff. However, it is planned that the associations will hire professional staff, and that an early priority of the staff will be to develop treatment and referral guidelines for FGPs, against which FGP performance can be monitored and assessed. Publication of a newsletter and other information is another priority.

3.0 CAUSES AND LIMITS OF THE SUCCESS OF THE ISSYK-KUL REFORMS

3.1 Origins of the Reform

The decision to designate Issyk-Kul Oblast as an "experimental zone" for the purpose of health care reform was driven almost entirely by the desire of the MOH and the Parliament to establish a Mandatory Health Insurance system. Their principal motivation was the expectation that mandatory health insurance would (1) generate new financial resources that would relieve the national government of some of the budgetary burden of maintaining the nation's financially unsustainable health care system and (2) introduce incentives to reduce inefficiency in the system. No other oblast had been able to move forward with insurance, so when the head of the Oblast Health Department at the time (1993-1994), Dr. Tolon Kyrgyzbaev, voiced his interest, the national government leapt at the chance. Underpinning this entire sequence of events was, and is, a widely-held belief that *inadequate financing* is the only real obstacle preventing a fundamental improvement in the quantity and quality of health care in Kyrgyzstan. Indeed, there seems to have been only token interest at the time in strengthening primary care, and little expectation of the far-reaching, radical reform that has developed since.

3.2 Opposition to Reform

The major opponents of primary care reform are the individuals who anticipate a reduction in status or influence under the new system, namely: the head physicians of the facilities from whom patients and, therefore, money are likely to be re-directed to the FGPs. In the previous health care system, status among senior managers was measured in terms of funding levels which, in turn, were a direct function of the size of the facility under a manager's control and the numbers of that facility's staff and patients. Thus, if the 187 physicians and 247 nurses now working for FGPs were officially removed from the personnel rosters of the polyclinics where they previously worked, the polyclinics' aggregate approved staffing level would be reduced by about 20 percent. According to current *prikazy*, many heads of facilities then would face reduced salary levels, many other senior and junior staff (whose own jobs depend on overall staffing levels) might have to be dismissed, and some facilities might have to be closed outright.

3.3 Importance of the Marketing Campaign

The marketing campaign helped substantially: to demonstrate consumer interest in, and acceptance of, primary care reform; to embolden interested providers, thereby magnifying the "bandwagon effect" noted previously; and to educate and inform consumers, providers, and especially political and administrative leaders regarding numerous aspects of health care reform.

For example, one of the most difficult problems that health reformers have faced throughout the NIS is to gain cooperation from the Finance Ministry and its local branches. In Kyrgyzstan, however, the public awareness and marketing campaigns have been so thorough that local finance authorities are well aware of the reforms and know and understand the vocabulary of the reforms and of primary health care generally. Most importantly, finance officials in Issyk-Kul Oblast have supported the reforms; while still among the most "conservative" government officials in the oblast, they have been educated by the public's interest and biting dissatisfaction with the current health care system. This has enabled the supporters of the reforms to establish a dialogue and to begin to work out with the finance department many of the specific problems associated with the shift to fundholding.

3.4 Problems with Financing

The main obstacles to the reforms so far have been financial in nature. The national government promised to provide a total of 1.2 million som (about $70,000) for incentive and bonus payments to the FGP physicians, but the money has not materialized due to severe budget constraints. Thus, while FGP staff have been working longer and more intensively than they did previously, they have received no additional compensation. Fortunately, the experiments have offered physicians other, non-financial rewards: e.g., the heightened professional satisfaction associated with the information gained from training, the opportunity to treat a wider variety of patients and indications, greater independence and responsibility, and the greater satisfaction expressed by many patients.

Perhaps more important than the lack of funds for incentive pay have been the delays in the introduction of capitated financing and in the development and implementation of fundholding. The delays are due partly to the shortage of funds, but also to continued resistance from the Ministry of Finance and the Oblast Finance Department, as well as from individuals within the MOH and other health providers in the oblast, who are not yet fully comfortable with the direction of change these reforms represent.

Some of the problems associated with capitated financing and fundholding are presently being worked out in the pilot experiment now underway in Karakol. However, it already is clear that before capitation and fundholding can be introduced on a large scale, two different sets of issues will need to be resolved. One has to do with the pooling of available funds, for which the Oblast Health Department must have authority, if it is to be able to pull together enough funding from the overall health budget in order adequately to support the FGPs. Clearly, FGP fundholding cannot proceed, if current facilities, especially the hospitals, continue to be financed at historic levels. A second set of issues has to do with the rules and regulations of financing and accounting. When the first tranche of funds was transferred into the Mandatory Health Insurance Fund, the banks panicked—they had no mechanisms for dealing with "non-government" funds—and, as a result, froze 90,000 som for nearly two months. Also, the Oblast Finance Department has severely limited operations of the Fund, because no financial reporting mechanism to account for the its uses of funds has been developed, which is acceptable to the Ministry of Finance. While conflicts over such rules and regulations might seem to be minor, unless they are resolved in advance of the implementation of capitation and fundholding, there is a serious risk of interruptions in funds flows that could easily bankrupt FGPs almost before they have a chance to operate.

3.5 *Prikazy* and Quality Assurance

Everyone—FGP physicians, local officials, international donors and consultants—agree that the unsystematized mass of *prikazy* constitutes a major obstacle and threat to reform. On a positive note, most Kyrgyz health officials acknowledge openly that most *prikazy* are outdated, and that many simply are unenforceable, owing to inadequate levels of funding. At the same time, the *prikazy* and the closely-related "medical economic standards" (treatment guidelines issued and mandated in the form of *prikazy*) have played an important role in limiting the development of primary health care in Kyrgyzstan and in the other NIS. Some local experts estimate, for example, that between 75 percent and 85 percent of patients who come to primary care providers with complaints that, in other countries, are normally treated by the primary care physician him- or herself must instead, according to *prikazy*, be referred to specialists.

By some accounts, *prikazy* increasingly are disregarded when viewed as impractical. And some national Kyrgyz health officials quietly have sought advice and help from international experts in developing means of reducing or eliminating the baneful effects of the *prikazy*. At the same time, the *prikazy*, and particularly the medical economic standards, constitute the health care system's basic mechanism for quality assurance, and there is widespread reluctance to change them radically before an acceptable alternate mechanism has been developed and instituted in their place.

4.0 CONCLUSIONS

Both the scale and the scope of the reforms in Issyk-Kul are striking. As stated earlier, there seems to be fuller recognition and understanding among the officials of this oblast than in most other regions of the NIS that the strengthening of primary health care is genuinely *radical health care reform* requiring far-reaching changes in: the organization, delivery, financing, and management of health care, both at the primary level and in inpatient facilities; the knowledge, skills, and attitudes of both physicians and their patients; and the technologies used to measure and monitor the provision of care and to ensure the highest possible quality of care.

In addition, like any radical reform, a real strengthening of primary health care requires patient, skillful leadership and a considerable amount of time. Although the reforms in Issyk-Kul are still in their early stages and have not yet demonstrated conclusively their clinical and economic effectiveness, a distant observer can only be impressed by these *subjective* causes of Issyk-Kul's success—the unusual vision and stubborn persistence of the oblast government and of many individual physicians, without which the striking progress that has been made so far would surely have been impossible.